

# **SUBCOMMITTEE NO. 3**

## **Health & Human Services**

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# **Agenda**

**Chair, Senator Denise Ducheny**

**Senator George Runner**  
**Senator Tom Torlakson**



**May 9, 2005**

**2:00 PM**

**Room 3191**

### **Agenda**

**(Diane Van Maren &  
Anastasia Dodson)**

<b><u>Item</u></b>	<b><u>Department</u></b>
<b>4200</b>	<b>Department of Drug and Alcohol—<i>Vote Only Issue</i></b>
<b>0530</b>	<b>Health and Human Services Agency—<i>Over Due Reports</i></b>
<b>4280</b>	<b>Managed Risk Medical Insurance Board—<i>Selected Issues</i></b>
<b>4260</b>	<b>Department of Health Services—<i>Selected Issues</i></b>
<b>4440</b>	<b>Department of Mental Health—<i>Capital Outlay Issues</i></b>

**PLEASE NOTE:** Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding these departments will also be discussed at the Governor's May Revision hearings. *Please* see the Senate File for dates and times of these hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

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## **RECOMMENDED FOR VOTE ONLY**

### **A. 4200 Department of Alcohol and Drug Programs (DADP)**

#### **1. Proposition 63 Positions**

**Issue:** To reflect the activities required by Proposition 63, the Mental Health Services Act, which became effective January 1, 2005, the Administration request a spring finance letter to establish 2.0 three-year limited term positions for the Department of Alcohol and Drug Programs (DADP). These positions would be funded by the new state Mental Health Services Fund established by Proposition 63.

**Background:** Proposition 63, the Mental Health Services Act (Act), which became effective January 1, 2005, established a state personal income tax surcharge of one percent on taxpayers with an annual taxable income of more than \$1.0 million. The funds from this surcharge are deposited into the new state Mental Health Services Fund, and will be used for state and county planning and implementation consistent with the Act's provisions. The Act provides for the expansion of mental health services and incomes specific provisions related to education and training of the mental health workforce, development of innovative program and integrated plans for prevention, intervention and system of care services, investment in capital facilities and technology needs, and enhanced oversight and accountability.

The estimated revenues in the Fund total \$254 million in 2004-05 and \$683 million 2005-06. While most of the revenue will be available to county mental health programs, the Act authorizes up to 5 percent of the revenue in the Fund annually for state administration. Funding for state administration is projected to be \$12.7 million in 2004-05 and \$34.2 million 2005-06.

The requested DADP positions would be used to provide assistance to counties in the planning, implementation, and evaluation of co-occurring mental health and alcohol and other drug programs. This augmentation would enable the DADP to build upon existing collaborative efforts with the Department of Mental Health to provide statewide leadership and coordination of local efforts to implement services for those with co-occurring disorders.

Although the Administration requests 2.0 three-year limited-term positions for the DADP, the LAO notes that current statute only allows for the establishment of two-year limited-term positions. Therefore the LAO recommends that the DADP positions be established as two-year positions.

The Subcommittee previously heard requests for Proposition 63 positions from the Department of Mental Health, the Department of Health Services, the Department of Education, the Department of Rehabilitation, and the Department of Social Services.

**Subcommittee Staff Recommendation:** Approve the requested positions, but reflect authority for two-year limited term positions, rather than three-year positions.

## **ITEMS FOR DISCUSSION**

### **A. CA Health & Human Services Agency—Over Due Reports (See Hand Out)**

**Issue:** The Administration has several reports due to the Legislature which are late. Discussions regarding some of these reports have occurred through out the Subcommittee process.

During these discussions, it was unclear as to (1) how reports are tracked by the Administration, and (2) when each report will be provided to the Legislature as required by statute, Budget Bill Language or Supplemental Reporting Language. As such, the CA Health & Human Services Agency (CHHS Agency) has been requested provide an update to the Subcommittee as to their status.

The CHHS Agency has provided the Subcommittee with a list of the reports and is prepared to provide a status update.

#### **Questions:**

1. CHHS Agency, Please provide a summary of the list and the intent of the Administration to provide the reports to the Legislature.

## **B. Managed Risk Medical Insurance Board**

### **1. Managed Risk Medical Insurance Program (MRMIP)**

**Issue:** Through discussions with the MRMIB, it has been found that the MRMIP has a sizable reserve—about \$20.2 million (Proposition 99 Funds)--, primarily due to a one-time settlement with certain health plans. According to the MRMIB, only \$2 million is needed in order to maintain a prudent reserve. As such, about \$18.2 million (Proposition 99 Funds) in one-time only funding is available for expenditure. The Governor’s budget did not identify this large reserve for any expenditure.

According to the MRMIB, the growth in the fund balance for the MRMIP is primarily attributable to prior year claims. As a new program serving people who had been denied health care coverage because of their high risk, there was a concern from the plans that they would incur high loss-ratios for the MRMIP participants. Since the reconciliation of actual cost data would take several years to complete, the monthly payments to the plans were based on negotiated loss-ratios.

A reconciliation of claims data was completed for years 1991-2002 and it was determined that some plans had actual loss-ratios that were lower than anticipated. Therefore, the MRMIB was able to recoup these over-payments to MRMIP participating plans and subsequently changed the methodology for the payments. Thus a large recoupment of this type should not be repeated.

It should be noted that existing statute (1) requires a reserve which is “sufficient to prudently operate the program”, and (2) enables any excess moneys remaining in the fund at the end of any fiscal year to be carried forward to the next succeeding fiscal year.

The Governor’s budget proposes expenditures of \$ 40 million (Proposition 99 Funds) for the MRMIP which is the amount at which it has been funded for many years. The \$20.2 million reserve is above this amount.

No General Fund money is utilized in the MRMIP and the program is not authorized to access General Fund support. The MRMIP has always been required to operate within the \$40 million annual appropriation.

**Background—Description of the Managed Risk Medical Insurance Program:** The Managed Risk Medical Insurance Program (MRMIP) provides comprehensive health insurance coverage for individuals who are generally unable to obtain coverage in the individual insurance market or are able to obtain insurance only at a very high cost. Typically these individuals are considered by insurers to be high-risk since they have had a pre-existing condition that was diagnosed or treated by a doctor prior to the individual’s enrollment in health insurance. While other state programs directly purchase health insurance coverage for individuals, MRMIP reimburses insurers when individuals incur high medical costs that exceed the regular health coverage provided to them by that insurer.

**Background—Description of the Steven M. Thompson Physician Corps Loan**

**Repayment Program:** The Steven M. Thompson Physician Corps Loan Repayment Program, operated by the Medical Board of California, is used to repay student loans for physicians and surgeons practicing in medically underserved communities.

Existing law creates the Medically Underserved Account for the purposes of the program. The fund consists of private donations and transfers from the Contingent Fund of the Medical Board which is supported by fees. The total amount of the transfers from the Contingent Fund to the Medically Underserved Account is \$3.450 million (\$1.150 million annually for three consecutive years which began in 2003). As such, the last transfer occurs in 2005-06.

**Background—Description of the Rural Demonstration Projects in the HFP:** The Rural Demonstration Projects within the Healthy Families Program (HFP) have been operational since the inception of the HFP. These projects have used different strategies, contingent on the rural area's needs, for addressing barriers faced by residents of rural areas in receiving health care. Examples have included (1) purchasing dental equipment; (2) improving patient tracking systems; (3) extending clinic hours during certain seasons; (4) establishing telemedicine capabilities; and (5) improving coordination with local drug and alcohol providers.

The Governor's budget proposes funds of \$2.8 million (\$991,000 Proposition 99 Funds and \$1.8 federal S-CHIP Funds) for the Rural Demonstration Projects. As noted, the state currently obtains a 65 percent federal match for these projects. Proposition 99 Funds are used by this program to draw a federal match as provided in legislation adopted as part of the Budget Act of 2003 (i.e., AB 1763, Statutes of 2003).

**Legislative Analyst's Office Recommendation:** The LAO recommends the following:

- (1) Maintain a \$2 million (Proposition 99 Funds) reserve for the MRMIP;
- (2) Repeal existing statute that provides for a reserve specifically for the MRMIP;
- (3) Repeal existing statute that enables the MRMIP to carry forward any excess moneys remaining in the fund at the end of any fiscal year to the next succeeding fiscal year; and
- (4) Appropriate the remaining \$18.2 million (Proposition 99 Funds) from the MRMIP reserve to either support other Proposition 99-Funded programs *or* to backfill for General Fund support for activities that are consistent with the specified uses of Proposition 99.

The LAO recommends elimination of the reserve requirement because Proposition 99 Fund accounts maintain a separate reserve which can be accessed when necessary. Therefore, a special MRMIP reserve is not necessary.

**Subcommittee Staff Comment and Recommendation:** First, Subcommittee staff concurs with the MRMIB and LAO to provide for a prudent reserve of \$2 million (Proposition 99 Funds) for the MRMIP for 2005-06.

Second, it is also recommended to concur with the LAO to repeal existing statute regarding the MRMIP to maintain a special reserve for the program. However, based on recent conversations with the MRMIB, it is recommended to *not* repeal existing statute that enables the MRMIP to carry forward a reserve to future fiscal years (i.e., not implement item (3) in the LAO recommendation list, above).

The MRMIB notes that a \$2 million (Proposition 99 Funds) reserve would not accumulate from year to year if the carry forward language is maintained because the existing transfer authority (i.e., the transfer of Proposition 99 Funds to the MRMIP Fund) only occurs when funds are needed (up to the \$40 million maximum) to support caseload. As such, if a \$2 million reserve is provided for 2005-06, this level of reserve would not be increased in future fiscal years due to the carry forward language.

Third, it is recommended to provide \$3 million (Proposition 99 Funds) to the Steven M. Thompson Physician Corps Loan Repayment program by transferring these funds to the Medically Underserved Account within the Medical Board of California where they can be continuously appropriated and used for the program until fully expended.

Fourth, it is recommended to provide an increase of \$5.7 million (\$2 million Proposition 99 Funds and \$3.7 million federal S-CHIP Funds) to the Rural Demonstration Program. Appropriating \$2 million of these one-time only Proposition 99 Funds would be a good use of one-time only funding.

Fifth, it is recommended to use the remaining \$13.2 million (Proposition 99 Funds) to backfill for General Fund support in the California Children's Services (CCS) Program. The intent of this action would be to serve as a one-time only offset to General Fund support for 2005-06, and not as an on-going source of funding for the CCS Program.

The following summarizes the fiscal component of the Subcommittee staff recommendation:

- |  |                         |
|--|-------------------------|
| • MRMIP reserve available  | = \$20.2 million        |
| • Maintain a \$2 million reserve   | = <u>\$ 2 million</u>   |
| • <b>Amount Available for Expenditure</b>  | <b>= \$18.2 million</b> |
| • Transfer \$3 million to the Steven M. Thompson Physician Corps Loan Repayment program  | = \$3 million           |
| • Appropriate \$5.7 million (\$2 million Proposition 99 Funds) to Rural Demonstration Projects.  | = \$2 million           |
| • Shift \$13.2 million (Proposition 99 Funds) in one-time only funds to the CCS Program to backfill for General Fund support for 2005-06 only. | = \$13.2 million        |

Further, it is also recommended to adopt Budget Bill Language for Item 4260-111-0001 (i.e., DHS item that governs the CCS Program funding) to reflect the Legislature's intent regarding the \$13.2 million backfill. The proposed language is as follows:

Of the amount appropriated in this item for the California Children's Services (CCS) Program, \$13.2 million in Cigarette and Tobacco Product Surtax Fund moneys shall be used on a one-time only basis to support the program. It is the intent of the Legislature to fully support and fund the CCS Program in subsequent fiscal years.

**Questions:**

1. LAO, Please provide a summary of the key components of the \$20.2 million reserve, including your recommendation to eliminate two pieces of state statute.
2. MRMIB, Please provide your perspective.

## **C. Department of Health Services**

### **1. Medi-Cal to Healthy Families Accelerated Enrollment by Counties**

**Issue:** In the **Subcommittee hearing of April 4th** during discussions regarding the “bridge” between Medi-Cal and the HFP, an issue was raised regarding the temporary enrollment of children into Medi-Cal pending their HFP eligibility. **In the April 25th Subcommittee hearing** this issue was discussed more comprehensively and it was requested for the Administration to provide technical assistance regarding a fiscal analysis.

Specifically, County Welfare Departments encounter children who are either not eligible for Medi-Cal or would have a high share-of-cost in Medi-Cal but would most likely be eligible for enrollment into the HFP. However presently the counties cannot enroll these children into the HFP because they do not have the authority to do so. Therefore, these children often have to wait, uninsured, for 4 to 8 weeks for a formal eligibility determination by the HFP.

It has been suggested to create a Medi-Cal to HFP accelerated enrollment program which would authorize counties to temporarily enroll children into the **no-cost** Medi-Cal Program if a county deems that they are eligible for the HFP. The temporary enrollment would only be for the period during which the HFP is conducting the formal determination of the child’s eligibility for that program (not more than 60-days).

Under such an accelerated program, the state could receive the S-CHIP federal matching rate of 65 percent, versus the Medi-Cal federal matching rate of 50 percent. Temporary enrollment into Medi-Cal would enable the child to receive immediate necessary services.

This issue has been discussed previously in legislation during the 2003-04 Session (i.e., SB 142, Alpert, as amended March 24, 2003). This legislation was discussed in both the Senate Health and Human Services Committee, as well as Senate Insurance and Senate Appropriations. Though the bill was moving it eventually was amended and used for another purpose.

A substantial effort has been made by the Legislature to create a seamless system of health care coverage, whereby individuals can move easily between Medi-Cal and the HFP without losing coverage for any period of time. A Medi-Cal to HFP accelerated enrollment would fill-in a present gap in services.

The following assumptions are made regarding this proposal:

**Criteria for the Child to Meet for Enrollment**

- The child or parent or guardian has submitted a Medi-Cal application directly to the county;
- The child is newly eligible for full-scope Medi-Cal services and has been determined to have a share-of-cost;
- The child is under 19 years of age and has a family income at or below 250 percent of the federal poverty level; and
- The child or parent or guardian has given consent for the application to be forwarded to the Healthy Families Program.

**60-Day Health Benefits (Temporary Health Care)**

- Federal S-CHIP Funds (65 percent federal match) would be available for this purpose;
- Temporary health benefits would be effective on the first of the month in which the county found that a child met the specified criteria. The temporary health benefits would terminate at the end of the month in which the child was discontinued from the Medi-Cal Eligibility Data System (MEDS) due to the full enrollment in or ineligibility for Healthy Families Program; and
- Temporary health benefits would be identical to the benefits provided to children who received full-scope Medi-Cal benefits without a share-of-cost.

Based on technical assistance obtained from the DHS Fiscal Forecasting Office, it is assumed that 87,456 children would be eligible for 60-days worth of health care coverage in Medi-Cal fee-for-service, pending their application approval at the HFP. This assumes a January 1, 2006 implementation date. Estimated expenditures for 2005-06 would be as follows:

- **Total for administration and health care benefits** =\$3.4 million (\$1.2 million GF)
  - Health care benefits component =\$3.0 million (\$1.1 million GF)
  - County administration =\$366,000 (\$128,000 GF)
- **Annualized expenditures** are estimated to be \$10.2 million (\$3.6 million GF)

**Subcommittee Staff Comment and Recommendation:** A substantial effort has been made by the Legislature to create a seamless system of health care coverage, whereby individuals can move easily between Medi-Cal and the HFP without losing coverage for any period of time. A Medi-Cal to HFP accelerated enrollment would fill-in a present gap in services. As noted previously by the MRMIB in the April 25th hearing in which they provided technical assistance to the Subcommittee, this proposal makes good policy sense. If the Subcommittee wants to implement this proposal, the following action is recommended:

- Increase the Medi-Cal Program by \$3.4 million (\$1.2 million General Fund) to reflect funding for health care benefits and eligibility administration; and
- Adopt placeholder trailer bill legislation to implement the proposal, including to limit the benefit to 60-days, allowable only with federal S-CHIP funding being available

and other related technical aspects to be worked out with the DHS regarding Medical processing.

**Questions:**

1. MRMIB and DHS, From a technical assistance standpoint could you please comment on the proposal.

## **2. Governor Proposes to Capitate Adult Dental in Denti-Cal at \$1,000**

**Issue:** The Governor's January budget proposes to restrict the amount of dental services provided to adults to \$1,000 in any twelve-month "rolling" period (versus a calendar-year) for proposed *net* savings of \$48 million (\$24.5 million General Fund) in 2005-06. This proposal requires trailer legislation to enact. An implementation date of August 1, 2005 is assumed.

It should be noted that the Administration's original savings level of \$24.5 million General Fund as contained in the Governor's budget is being recalculated for May Revision and will decrease. This is because the DHS now believes it will be necessary to exempt dental services provided in nursing homes from the cap as well.

In addition, the DHS' original savings estimate will decrease even further because it did not take into consideration the proposals effect on individuals with developmental disabilities. According to the DDS, the DHS cap would affect about 1,680 Regional Center consumers at a cost of \$1.160 million General Fund for 2005-06 (11 months). If services are not available through Medi-Cal, then the Regional Centers must purchase them using 100 percent General Fund support. The DDS notes that this estimate will be refined at the time of the May Revision.

**It should also be noted that the Administration's cap would be retroactive back to January 1, 2005.** In other words their proposal would commence as of August 1, 2005 and then look back to January 1, 2005 to total up the claims. Therefore, a Medi-Cal enrollee could have dental claims exceeding the \$1,000 even though the law, if adopted, was effective only as of August 1, 2005. The DHS states that going retroactive is the only way to achieve savings in the budget year.

The Governor's proposed **net** savings in his January budget assumes the following:

- A reduction of \$50.2 million (\$25.1 million General Fund) in Medi-Cal dental services;
- An increase of \$4 million (\$1 million General Fund) for a tracking system; and
- An increase of \$165,000 (\$59,000 General Fund) to fund 1.5 new DHS positions (Information Systems Specialist and a half-time Staff Counsel).

The DHS states that the \$1,000 limit would not apply to:

- Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in serious impairment to bodily functions (such as a very severe infection, hemorrhage, or trauma related to a dental origin);
- Medical and surgical services provided by a dentist which, *if provided by a physician*, would be considered physician services, including complex maxillofacial surgical procedures and comprehensive oral reconstruction; and
- Services that are federally mandated under 42 Code of Federal Regulations, Part 440, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

According to the DHS, about 900,000 adults enrolled in Medi-Cal actually access dental services annually. Of these individuals, about 95,000 Denti-Cal enrollees would be affected by the \$1,000 limit. As noted in the table below, over 55 percent of these individuals, or 52,900 people, are aged, blind and/or disabled.

**Table: Average Monthly Adult Eligibles Impacted by Proposed Cap**

Type of Adult Eligible	Total Adult Eligibles	Eligibles Impacted by Cap
Aged, Blind, Disabled	1,447,500	52,900
All Other Adults (21-64 years)	1,552,000	42,000
<b>Total</b>	2,998,500 (about 900,000 access dental annually)	<b>94,900</b>

It should be noted that the Administration will still continue to use their existing “treatment authorization request” (TAR) process for the dental program. As such, TAR’s will continue to be reviewed and adjudicated regardless of the 12-month rolling period.

The Administration assumes expenditures of \$4 million (\$1 million General Fund) in 2005-06 for the Denti-Cal fiscal intermediary to track each adult enrollee’s dental usage. According to the DHS, system modifications are necessary to accumulate the total dollars spent by enrollee, to then edit the incoming claims for exclusions to the cap, and add a capability for providers to call in and “look-up” the balance available for each enrollee.

Participating Denti-Cal providers would need to access this tracking system to check on the usage status of each and every Denti-Cal patient. The DHS maintains that upon implementation of the proposed cap, dental providers would be able to check the enrollee’s level of expenditures through a telephone voice response system. Within six-months, the DHS would include a web-based retrieval system.

According to the DHS, the proposed tracking system would operate as follows:

1. Claim is received by Medi-Cal fiscal intermediary (presently Delta Dental).
2. System checks to see if the billed service is excluded from the \$1,000 cap.
3. If the service billed is excluded, the claim moves forward to adjudication.
4. If the service is not on the exclusion list, the system checks the prior 12-month paid claim history (back 12 months from the billed date of service).
5. If claim payment history shows that the dental cap will not be exceeded, the claim will move forward to adjudication.
6. If the cap is met, the claim will be denied.

Dental providers would be encouraged to check the tracking system prior to scheduling or providing any dental services to the enrollee. This is because providers will not be able to directly bill Medi-Cal enrollees that are above the \$1,000 cap without a written agreement with the enrollee prior to rendering the service.

With respect to state support, the DHS is seeking an increase of \$165,000 (\$59,000 General Fund) to hire one Associate Information Systems Analyst and a half-time Staff Counsel to implement the proposal.

Finally, it should be noted that the Administration's proposed trailer bill language provides extremely broad authority to the DHS by enabling them to implement this proposal through all county letters, provider bulletins, or similar instructions. Thereafter, the DHS may adopt regulations.

**Background—Overview of Existing Denti-Cal Program:** Access to dental services for children under age 21 is required by federal law, whereas adult dental services are considered “optional”. Generally, covered dental benefits for children and adults include: (1) diagnostic and preventive services such as examinations and cleanings, (2) restorative services such as fillings and (3) oral surgery services. Many services such as crowns, dentures and root canals require prior authorization.

State law requires most Medi-Cal enrollees to pay a co-payment for dental care. A \$1 co-payment is required for services provided in a dental office and a \$5 co-payment is required for non-emergency care provided in an emergency room. As directed by federal law, services cannot be denied to a recipient if a co-payment is not provided

It is well recognized that the reimbursement rates currently paid under Denti-Cal are very low—generally about 40 to 50 percent of the usual and customary fee charged by dentists in California. In addition, this program has implemented considerable cost containment measures over the past several years. All of these aspects would still be retained under the proposed cap.

**Prior Subcommittee Hearings:** In the Subcommittee's March 2nd hearing, numerous issues were raised regarding the Administration's dental capitation proposal. In the April 4th Subcommittee hearing, a detailed discussion was had regarding various options.

**Subcommittee Staff Comment and Recommendation:** The Administration seeks to implement a \$1,000 cap (retroactively) in Denti-Cal in an effort to align benefits more closely to the commercial market place. However, Denti-Cal is quite dissimilar to the commercial market place. It serves more medically needy individuals than the commercial market, reimburses at rates which are generally 40 to 50 percent of the usual and customary fee charged by dentists in California, and has eliminated or restricted services to enrollees due to budgetary constraints over the years.

Based on comments received from prior Subcommittee hearings, it is recommended to adopt the following:

- Placeholder trailer bill language to implement a \$1,800 cap over a one-year period using a calendar year and **no retroactivity**. An implementation date of January 1, 2006 is to be assumed. (The DHS date of August 1, 2005 was not realistic given the need to implement a tracking system and the practicality of using a calendar year such as done in the commercial marketplace.)
- Exclude the following involved procedures from the cap: (1) emergencies, dental services provided in long-term care facilities and related items as contained in the DHS proposal, (2) dentures, and (3) complex oral and maxillofacial surgeries. (This includes the following procedures codes 275, 277, 285, 289, 700 to 724, 900 to 916, and 974 to 985.)

- Provide a three-year sunset date of January 1, 2009, unless extended or a new program is implemented. In this manner the Legislature can revisit the issue and see if any adjustments for rates or services are warranted.

This proposal would restructure the program and provide for savings in 2006-07. It would provide sufficient time for the DHS to implement the tracking system so Dentists can obtain information about their patient's pending cap level. It also would provide sufficient time for both Dentists and Medi-Cal enrollees to become informed about the pending change. Using a retroactive approach as proposed by the DHS is not good policy.

**Questions:**

1. DHS, Please explain how the retroactive aspect of your proposal would work?

### **3. Medi-Cal Managed Care—Discussion of the DHS Timeline (See Hand Outs)**

**Issue:** As has been discussed at several Subcommittee hearings, the Administration is proposing to expand Medi-Cal Managed Care (See background below for description).

In the Subcommittee's May 2nd hearing, the DHS provided a timeline of their proposal which contained additional components that were not address in the original timeline released in January. (The numbers shown in shaded boxes of the DHS chart mean that these actions are contingent upon completion of other actions.)

As such, the Subcommittee has requested the DHS to step through this newly provided timeline.

**Subcommittee Staff Comment:** In reviewing the timeline provided by the DHS on Monday, May 2nd, the following key aspects should be noted. (The number reference corresponds to the DHS timeline hand out.)

- **1. New Rate Methodology:** A contractor—Mercer, Incorporated—is in the process of being hired by the DHS to conduct an analysis of the existing rate system (considerable issues here) and to develop new rate methodologies for the entire Medi-Cal Managed Care system (Two-Plan Model, Geographic Model and County Organized Healthcare System). This activity is estimated by the DHS to be completed in April 2006. This means that the “new” rates will not be available for the first DHS designated expansion counties (i.e., mandatory enrollment of aged, blind and disabled in Los Angeles, Riverside and San Bernardino counties). Further, it is unclear when the Legislature would be provided information regarding the new rate methodology which would be needed for appropriation purposes.
- **2. Current Regulation Revision/Update:** The existing regulations for Medi-Cal Managed Care as it presently operates need to be redone as noted by the DHS and LAO in our May 2nd hearing. This activity is estimated to take from May 2005 to November 2006. A considerable amount of work needs to be completed here.
- **3. Obtain Federal Authority for Additional County Organized Healthcare Systems (COHS):** Existing federal law limits California from having more than 5 COHS'. Presently we have 5 covering a total of 8 counties (See background below regarding our existing system). There are several counties interested in becoming COHS', including Ventura and Merced. Federal approval is needed for any additional county to become their own COHS. However, counties can be added to an existing COHS (such as San Luis Obispo being added to Santa Barbara).
- **6. Standardize all Medi-Cal Managed Care Contracts:** This is a “core” program update that needs to be done whether or not any expansion is adopted. The DHS anticipates that this will commence in July 2005 and be completed by March 2006. Again, this is a considerable amount of work and will require discussions not only with health care plans but should also include discussions with independent entities who can provide perspectives regarding encounter data reporting, performance measures and quality assurance.

- 8. Final date for County Decisions on Managed Care Model: The DHS expects that by September 1, 2005, all of the 13 new expansion counties will be able to inform the DHS on which Medi-Cal Managed Care Model they will be implementing. This date appears to be very optimistic and could be viewed as not being considerate of county needs.
- 10 and 11. New Waivers and State Plan Amendments to the Federal CMS: The DHS shows the period from October 2005 to July 2006 for any Waivers and State Plan Amendments to be crafted, submitted to the federal CMS and approved. Given recent experiences, it is very unlikely that the federal CMS could approve Waivers within 90-days of receipt as shown in the chart.
- 17, 18, and 19. “Boilerplate” Language for Contracts with Health Plans and Federal CMS: The DHS assumes that from February 2006 to June 2006 that “boilerplate” language for the contracts will have been negotiated with the health plans and that the federal CMS will have approved this language. Again, the time period seems rather optimistic.
- 20. Readiness Review and Contract Monitoring Tools Completed: This is a very critical aspect of the overall proposal for it is how the DHS will determine whether counties and health plans are ready for enrollment of all Medi-Cal individuals, including the aged, blind and disabled. This is to occur from May 2006 to September 2006. It is not clear at this time what the readiness review will fully encompass or what contract monitoring “tools” will be used.
- 21. New Waiver for COHS Counties: This Waiver will need to be redone to potentially add new counties to existing COHS’ and to develop new COHS areas. This Waiver, which requires federal CMS approval, is assumed to be completed by May 2007.
- Los Angeles, Riverside and San Bernardino are then expected to commence mandatory enrollment of aged, blind and disabled by January 1, 2007.

**Background—Summary of the Administration’s Proposed New Managed Care Expansion:** The Administration’s Medi-Cal Managed Care expansion would be achieved through a phased-in process over a twelve to eighteen month period commencing in January 2007.

The Administration’s proposal would require (1) state statutory changes, (2) approval of a federal Waiver, and (3) adoption of state regulations (though the Administration may choose not to use the regulation process for some or all program components).

It is anticipated that 816,000 additional Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion.

Of these proposed new enrollees, 554,000 would be aged, blind or disabled. There are about 280,000 aged, blind or disabled individuals presently enrolled in the existing Medi-

Cal Managed Care Program. As such, the 554,000 represents an increase of about 100 percent.

The proposed new expansion assumes the following **key components**:

- **Expansion to 13 New Counties:** The Administration would expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

The Administration assumes the following Managed Care model configurations for these new counties:

- Include El Dorado and Placer counties in the existing Sacramento GMC;
- Include Imperial County in the existing San Diego GMC;
- Convert Fresno County (now a Two Plan) to a GMC Model and include Madera, Merced, and potentially Kings counties;
- Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

- **Aged, Blind and Disabled Individuals (Mandatory Enrollment):** The DHS has identified 36 Medi-Cal aid codes which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. It is assumed that about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09. The 554,000 new enrollees represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

- **Acute and Long-Term Care Integration (ALTCI) Proposal:** As noted under Agenda item 4, below, the Administration is in the process of *changing* this proposal to cover only 3 counties—Orange, San Diego, and Contra Costa.

Under this proposal, health plans would provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities (i.e., Medi-Cal and Medicare eligibles) and would incorporate primary, acute and long-term care services, and home and community-based services and providers in their networks (such as social services, personal care services provided under IHSS, nursing facility services, and others).

The integration of Medi-Cal and Medicare funding and services would occur at the health plan level.

**Summary of Existing Medi-Cal Managed Care System:** The DHS is the largest purchaser of managed health care services in California. Currently, some form of Medi-Cal Managed Care serves about 3.2 million Medi-Cal enrollees, primarily families and children and is in 22 counties. Only 280,000 enrollees, or about 9 percent, are seniors and individuals with developmental disabilities. The state has federal approval to operate this *existing* system under State Medicaid Plan authority.

The Medi-Cal Managed Care system utilizes three types of contract models— (1) the Two Plan, (2) the County Organized Health Systems (COHS), and (3) Geographic Managed Care (GMC). About 74 percent of Medi-Cal managed care enrollees are in a Two Plan model which covers 12 counties. There are five COHS (federal law limit) that serve eight counties. The GMC model is used in two counties.

For people with disabilities, enrollment is *voluntary* in the Two Plan and GMC model, and *mandatory* in the COHS. In addition, certain services are “carved-out” of the Two Plan and GMC models, as well as some of the COHS’s. Most notably, Mental Health Managed Care, and the California Children’s Services (CCS) Program are “carved-out”, except for CCS in some selected counties which operate under the COHS model. Per existing state statute, CCS is carved-out until September 1, 2008.

**Background--Two Plan Model (in 12 Counties):** The Two Plan model was designed in the late 1990’s. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, other children and families, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.

Plan Name	County	June 2003 Enrollment
Alameda Alliance for Health (LI)	Alameda	73,840
Blue Cross of California	Alameda, Contra Costa, Fresno, Kern, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	360,760
Contra Costa Health Plan (LI)	Contra Costa	41,909
Health Net	Fresno, Los Angeles, Tulare	579,588
Kern Health Systems (LI)	Kern	69,432
La Care Health Plan (LI)	Los Angeles	824,271
Inland Empire Health Plan (LI)	Riverside, San Bernardino	232,318
Molina Healthcare of California	Riverside, San Bernardino	91,702
San Francisco Health Plan (LI)	San Francisco	28,796
Health Plan of San Joaquin (LI)	San Joaquin	56,046
Santa Clara Family Health Plan (LI)	Santa Clara	66,812
<b>Two Plan Model Total</b>		<b>2,425,474</b>

**Background—Geographic Managed Care (GMC):** The GMC model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. **Sacramento and San Diego counties contract with nine health plans that serve about 10.6 percent of all Medi-Cal managed care enrollees in California.**

Plan Name	County	June 2003 Enrollment
Blue Cross of California	Sacramento and San Diego	92,173
Community Health Group	San Diego	66,086
Health Net	Sacramento and San Diego	39,558
Kaiser Foundation Health Plan	Sacramento and San Diego	29,049
Molina Healthcare of California	Sacramento	20,208
Sharp Health Plan	San Diego	50,238
Universal Care	San Diego	12,810
UC San Diego Healthcare	San Diego	13,344
Western Health Advantage	Sacramento	15,713
<b>TOTAL</b>		<b>339,179</b>

**Background—County Organized Health Systems (Eight Counties):** Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model).

It should be noted that the capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in said county.

As noted in the chart below, about 540,000 Medi-Cal recipients receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about nine percent of all Medi-Cal enrollees. It should be noted that federal law mandates that only 10 percent of all Medi-Cal enrollees can participate in the COHS model.

Plan Name	County	June 2003 Enrollment
Cal Optima	Orange	281,839
Central Coast Alliance for Health	Monterey, Santa Cruz	84,363
Partnership Health Plan	Napa, Solano, Yolo	77,704
Health Plan of San Mateo	San Mateo	45,742
Santa Barbara Regional Health Authority	Santa Barbara	50,276
<b>TOTAL</b>		<b>539,924</b>

**Questions:**

1. DHS, Please describe each key component contained in the newly provided timeline.
2. DHS, Which aspects of this schedule do you think will be most difficult to meet?

**4. Acute Long-Term Care Projects—Administration’s Revised Draft Language**  
*(See Hand Out)*

**Issue:** Based on discussions with the Subcommittee and others, the Administration has revised their proposal for developing Acute and Long-Term Care Integration Projects.

Under their revised language, it is clarified that three projects would be created in three county areas--Contra Costa, Orange and San Diego.

The Administration notes that this new draft language **is still a work in progress** and they would like to continue conversations regarding its content and structure.

The following *key* changes should be noted in the Administration’s revised proposal:

- Limits the ALTCI to three counties (to be Orange, San Diego and Contra Costa);
- Describes the integrated services to be provided (paragraph (4) on page 3 of language);
- Requires ALTCI counties to continue their financial maintenance of effort for programs and services integrated under the statute. The amount of a county’s maintenance of effort shall be based on the county’s share of the non-federal share of annual expenditures for the In-Home Supportive Services (IHHS) Program in state fiscal year 2003-04.
- Enables entities providing personal care services to enter into contracts with an ALTCI entity to provide personal care services;
- Excludes inclusion of services provided by Regional Centers. As such Regional Centers will continue to provide services independent from ;
- Excludes inclusion of County specialty mental health services. As such County Mental Health Plans will continue to operate outside this model;
- Directs that the DHS will perform an evaluation of the model;
- Provides the Director of Health Services with very broad authority to seek any and all federal Waivers, and to contract on a bid or non-bid basis, or exclusive basis, for the ALTCI projects;
- Provides the Director of Health Services with very broad authority to implement the ALTCI projects through county letters, plan letters, provider bulletins, or similar instruction; and
- Provides for a sunset date of January 1, 2012.

**Background—Overall Concept of the Three ALTCI Projects:** Under the proposal, “Acute and Long Term Care Integration” (ALTCI) health plans would provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities (i.e., Medi-Cal and Medicare eligibles) and would incorporate primary, acute and long-term care services, and home and community-based services and providers in their networks (such as social services, personal care services provided under IHSS, nursing facility services, and others).

The chart below displays the differences between Medi-Cal Managed Care coverage and the newly proposed ALTCI.

<b>Traditional Managed Care Coverage</b>	<b>ALTCI Project Coverage</b>
Primary Care	Primary Care
Hospital Care, Emergency Room Services, Surgeries	Hospital Care, Emergency Room Services, Surgeries
Case Management of Medical Services	Case Management of Medical Services
Medi-Cal Scope of Benefits (all offered)	Medi-Cal Scope of Benefits
	Expanded Case Management across medical, social and supportive services with consumer participation as a priority and with interdisciplinary team support. Case Management would have a priority to avoid institutional placements.
	Nursing Facility Services
	Adult Day Health Care
	Personal Care Services (IHSS)
	Home and Community-Based Services (home modifications, personal emergency response systems, nutrition, and others necessary to avoid or delay inpatient nursing facility care.

The integration of Medi-Cal and Medicare funding and services would occur at the health plan level. As such, the participating health plans must also be federally approved as Medicare Plans (“Medicare Advantage plans), and must include Medicare prescription drug coverage.

ALTCI Projects would be reimbursed through a capitated payment from the state for Medi-Cal services and a capitated payment from the federal CMS for the Medicare services for eligible members. The projects would assume full risk for a comprehensive array of services including acute hospital care, nursing facility care and home and community based services and supports under this funding mechanism. The DHS states that capitated rates across the entire health and social support continuum creates fiscal incentives for the plans to provide proactive and preventive services to avoid higher costs in institutional settings.

**Summary Table of ALTCI Enrollment and Start Dates**

<b>ALTCI Projects</b>	<b>DHS Estimated Enrollment (Seniors and adults with disabilities)</b>	<b>DHS Proposed Start Dates</b>
Orange County	74,139 adults	September 1, 2006
Contra Costa	27,092 adults	January 1, 2007
San Diego	89,417 adults	March 1, 2007

Enrollment options for individuals would vary contingent upon eligibility for Medicare and the geographic area. For “Medi-Cal-only” individuals (about 40 percent of seniors and adults with disabilities) living in San Diego or Contra Costa, these individuals will have a choice to either (1) enroll or stay in a “traditional” Medi-Cal Managed Care Plan, (2) enroll in an ALTCI plan, or (3) be “defaulted” into an ALTCI plan if no choice is made.

For the dually eligible living in these two areas (60 percent are dually eligible), the individual can (1) enroll in an ALTCI project and maintain Medicare coverage separately, (2) enroll in an ALTCI project and enroll in the same plan for Medicare coverage and Medicare Drug coverage through a “Prepaid Drug Plan”, (3) enroll in a Program for All-Inclusive Care for the Elderly (PACE) plan if eligible and one is available, or (4) be “defaulted” into an ALTCI plan if no choice is made.

Since Orange County operates CalOPTIMA, all individuals would enroll into its ALTCI plan but could also maintain Medicare coverage separately if desired.

The DHS will use different approaches in selecting the ALTCI plans for the three areas since each area operates a different Medi-Cal Managed Care Model. In Orange County, CalOPTIMA will develop a service delivery system.

Contra Costa as a Two Plan Model will have Contra Costa Health Plan (local initiative) as well as a competitive procurement to select the second ALTCI plan (commercial plan). If the Contra Costa Health Plan does not want to participate as an ALTCI then a second competitive procurement would be done.

San Diego as a Geographic Managed Care Model would use a Request for Application process. The state would release specifications and requirements for ALTCI plans through the RFA process and would review and select participating ALTCI plans based on meeting both state and county requirements. The number of participating plans would be determined by the number of successful applicants.

Core major milestones that the ALTCI projects will need to meet (as presently identified) include the following:

- Apply to the federal CMS to become a Medicare Advantage Plan (subject to federal CMS timelines for Medicare applications);

- Access current home and community-based services provider capacity and utilization in the county. From this data, develop recommendations to the state regarding provide networks.
- Expand and draft ALTCI care management protocols and submit to DHS.
- Establish cultural competency standards including age and disability issues for enrolled populations.
- Participate with the state on Quality Assurance measures for enrolled populations.
- Establish policies to “operationalize” Quality Assurance measures that ALTCI plans must meet to serve the enrolled population.
- Identify assessment tool/protocol and ALTCI service authorization guidelines.
- Assess and build information technology support for comprehensive care management across medical and social services providers/functions.
- Enroll members.

**Subcommittee Staff Comment and Recommendation:** The Administration’s revised proposal to develop three ALTCI projects in these three counties has merit. Consumers with chronic care needs and long term care needs often must seek services and supports from several distinct health care programs and home and community-based service entities, each with its own separate assessment process and care plan. Discussions regarding the integration of programs that serve this community has been ongoing for several years.

Clearly, considerable work still needs to be done regarding the crafting of statutory language. In addition, the Administration needs to clarify its budget request based on the revised language and scope of the project.

It is recommended to hold this issue “open” pending receipt of May Revision and clarification of the budget request. Any draft, “placeholder” trailer bill language could also be addressed at this time.

**Questions:**

1. DHS, Please describe the key aspects of the revised, draft language on the ALTCI Projects.
2. DHS, Please describe how IHSS services would be provided under the ALTCI Projects.
3. DHS, Please describe your proposed schedule for implementation.
4. DHS,

## **5. Adult Day Health Care Program—Several Issues**

**Issues:** The Governor's January budget is proposing several changes to the Adult Day Health Care (ADHC) Program. In addition, a Finance Letter has also been submitted to the Subcommittee for consideration. However, recent conversations with the federal CMS, as discussed further below, have clarified that California must eventually submit a federal Waiver (not a State Plan Amendment) in order to maintain our Adult Day Health Care Program. As such, the Governor will need to make modifications to his January budget proposal at the May Revision.

All of the Governor's proposed issues to-date are as follows:

- **Moratorium & Rate Redesign:** The Governor's Medi-Cal budget proposes savings of \$49.9 million (\$25 million General Fund) to the ADHC by (1) continuing the "moratorium" implemented through the Budget Act of 2004 and accompanying trailer bill language, and (2) redesigning the existing rate system by "unbundling" it to distinguish certain expenditures from the overall bundled/comprehensive rate.

Of this total proposed savings amount, (1) \$45.3 million (total funds) is attributed to continuing the existing moratorium until December 2005 (six months), and (2) \$13.3 million (total funds) is assumed to be achieved from redesigning the rate to be effective as of January 1, 2006.

- **New Federal Waiver for ADHC Program:** The Governor's budget assumes that a new federal Waiver is in place for the ADHC Program by January 1, 2006.
- **Request for DHS State Staff:** The DHS has submitted a Finance Letter which requests an increase of \$48,000 (\$24,000 General Fund) to hire an Associate Governmental Program Analyst position beginning January 1, 2006 and ending January 1, 2008. The purpose of this position would be to assist in the restructuring of the ADHC Program by crafting a State Plan Amendment (SPA) for submittal and approval to the federal CMS.

As referenced above, the Budget Act of 2004 implemented a moratorium on the certification of new ADHC Providers (not enrollees) beginning as of August 16, 2004. This moratorium was intended to freeze the existing number of providers in place and not provide for any new licensures. The DHS had desired this action in order to mitigate growth in the program.

In addition, the federal CMS has expressed concerns about the structure of the ADHC Program. In a letter dated December 11, 2003, the federal CMS notified the state that California needs to submit a federal Waiver (1115 or 1915 (c)) in order to continue to receive federal financial participation (i.e., federal matching funds) for ADHC enrollees and services. The federal CMS has made it clear that changes to eligibility, the services offered, and the reimbursement methodology will likely need to be made under a Waiver.

Transitioning to a Waiver Program will require considerable fore thought particularly given federal requirements pertaining to cost-neutrality, eligibility, service structure and relates aspects.

Any federal Waiver proposal by the DHS would require state statutory change prior to implementation. The Administration is sponsoring policy legislation—AB 1258 (Daucher)—on this issue and it is proceeding through that process.

In addition, SB 642 (Chesbro) is also proceeding through the policy committee process and it would, among other things, make statutory changes to enable the DHS to obtain a federal Waiver for the ADHC Program as well.

**Background Over All—Existing Program:** Adult Day Health Care (ADHC) is a community-based day program which provides nursing, physical therapy, occupational therapy, speech therapy, meals transportation, social services, personal care, activities and supervision designed for low-income elders and younger disabled adults who are *at risk* for being placed in a nursing home.

ADHC has been a successful model for elderly individuals for they can obtain many services in one location. For these individuals, particularly those with mobility challenges, going to one place for health care results in better compliance with therapy, medication, nutrition, and exercise regimens. Under Medi-Cal, individuals can participate in ADHC from one to five days per week, but usually average about three days a week.

The general concept behind providing ADHC services is that they delay or defer individuals from going into nursing homes or other more costly forms of care and therefore, it saves Medi-Cal money. Compared to the monthly Medi-Cal cost of a nursing home at about \$3,400 per month, ADHC can cost as much as three to four times less. Currently, there are about 43,000 Medi-Cal recipients who receive ADHC services in any given month.

Further, there are about 300 ADHC facilities in the state that are certified in the Medi-Cal Program. Typically, each ADHC has the capacity to serve between 40 and 100 clients per day. According to the LAO, about 56 percent of the total number of ADHCs were located in Los Angeles County.

**Recent Concerns with ADHC Growth:** Both the DHS and the California Association for Adult Day Services (Association) have noted that the ADHC Program began to grow in 1999 after many years of exceedingly slow growth. Generally, some of the reasons for this growth included: (1) changes in the state's aging and immigrant demographics, and (2) the lifting of statutory restrictions against "for profit" ADHC providers.

**Background on Rates:** Currently Medi-Cal reimburses ADHCs at a "bundled rate"—a single rate which is paid per recipient, per day (minimum of a four-hour stay required). This rate includes payment for all required ADHC services as specified in Title 22, California Code of Regulations. This rate is set at 90 percent of the state's reimbursement rate for Nursing Facility—Level A (\$69.58 per day). This rate structure was the outcome of a legal settlement agreement done in 1993. This list of required services includes, among other, physical therapy, occupational therapy, speech therapy and recipient transportation to and from the ADHC facility.

**Constituency Concern and Request of Subcommittee (See Hand Out):** The Subcommittee is in receipt of proposed language regarding a modification to the existing “moratorium”. According to information provided, the proposed language would:

- Address a specific need in the San Francisco area regarding the Laguna Honda nursing facility and a need to utilize community-based resources;
- Allow ADHC provider expansion in Imperial County due to the number of low-income seniors residing in the county;
- Address a specific need in Napa County, as noted (see page 2 of hand out);
- Address a specific need in Humboldt County, as noted; and
- Enable 25 older adults with developmental disabilities to be phased-in for services as noted.

This language has been shared with the Administration who is presently reviewing it for both policy and fiscal implications.

**Subcommittee Staff Commend and Recommendation:** The Administration’s budget proposal is no longer applicable and must be revised at the Governor’s May Revision due to recent clarification regarding our program with the federal CMS.

First, the federal CMS has told the DHS that California must submit a federal Waiver in order to retain the program in perpetuity as a Medi-Cal Program service. The federal CMS has said that our existing federal match that we receive for these services is not at risk as long as we are working towards the crafting of a Waiver.

Second, a rate redesign cannot be done by the state until a comprehensive Waiver is crafted. As such, the rates cannot be “unbundled” and therefore, the Governor’s May Revision will need to be adjusted (i.e., the assumed \$13.3 million (total funds) in savings cannot be done).

Third, one of the purposes of implementing the “moratorium” was to freeze the program in place until a federal Waiver or State Plan Amendment could be crafted and put into place. The moratorium was meant to be a temporary measure.

Therefore, consideration of adjustments in areas that are very underserved and low-income, or have narrowly described special needs, should be considered pending the crafting of a Waiver. The proposed language is a very modest lessening of the moratorium.

The DHS has committed to providing the Subcommittee with a fiscal estimate regarding the proposed change to the moratorium. This information should be available at the May Revision. Further, the DHS is in the process of re-crafting their proposal as well.

It is recommended to hold this issue “open” pending (1) receipt of fiscal information to be provided by the DHS, as technical assistance, on the proposed modification to the moratorium, and (2) receipt of the Governor’s May Revision changes.

**Questions:**

1. DHS, Please provide a status update regarding your discussions with the federal CMS about restructuring the state's ADHC Program and crafting a Waiver.
2. DHS, Please comment on the proposed modification to the moratorium from a technical assistance basis.

**6. Proposition 99 Funded Programs for Budget Year—Issues “A” to “C”**  
**(See Hand Outs—multiple charts)**

**Overall Background on Proposition 99:** Proposition 99, the Tobacco Tax and Health Protection Act of 1988, established a surtax of 25 cents per package on cigarettes and other tobacco products, and provided a major new funding source for health education, indigent health care services, and resources programs.

Under the provisions of Proposition 99, revenues are allocated across **six accounts** based on specified percentages. Various programs, administered under several different state departments, are funded using revenues deposited in the specified accounts. The accounts are as follows:

- **Hospital Services Account:** This account receives **35 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided in hospital settings.
- **Physician Services Account:** This account receives **10 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided by physicians.
- **Unallocated Account:** This account receives **25 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided by physicians.
- **Research Account:** This account receives 5 percent of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant research activities associated with anti-tobacco efforts. This account also receives funding from Proposition 10—the California Children and Families First Act of 1998.
- **Health Education Account:** This account receives **20 percent** of the annual Proposition 99 revenues. Revenues from this account are used for various anti-tobacco education efforts. This account also receives funding from Proposition 10—the California Children and Families First Act of 1998.
- **Public Resources Account:** This account receives 5 percent of the annual Proposition 99 revenues and the funds are used for specified public resources.

Proposition 99 initially provided total revenues of about \$570 million for health care related programs. Since that time, revenues have declined as the use of tobacco products has diminished due to the success of the anti-tobacco media campaign and increased taxes (i.e., Proposition 10 from 1998). Proposition 10 holds harmless the Health Education Account and the Research Account of Proposition 99, but does not provide a backfill for the other health care accounts.

## **ISSUE “A”—Revised S-CHIP Language & Discussion of Use of Savings, and Related Programs**

**Issue and Prior Subcommittee Hearing:** As discussed in our April 4th Subcommittee hearing, the Governor assumes recognition of recent federal regulations under the State’s Children Health Insurance Program (S-CHIP) (Healthy Families in California) that declare an unborn child (from conception) may be considered an eligible child under the program.

Under these federal regulations a state may elect to extend eligibility to unborn children using federal S-CHIP funds (a 65 percent federal match rate) for health benefits coverage, including prenatal care and delivery. California would need to submit an S-CHIP State Plan Amendment (SPA) to the federal CMS for approval in order to obtain the 65 percent federal match.

At the April 4th hearing, the Subcommittee took action to (1) adopt trailer bill language regarding the action, (2) captured the \$68.046 million General Fund savings, and (3) captured the \$78.440 million in Proposition 99 savings. **These dollar savings are shown below in the table and are also the same savings level as assumed in the Governor’s January budget.**

**The Subcommittee did not as yet allocate these savings.**

<b>Summary of State Dollar Savings and Federal Fund Increases</b>			
<b>Governor’s Proposed Funding Shifts</b>	<b>2005-06 Fund Shifts</b>		
	<b>Prop 99 Funds</b>	<b>General Fund</b>	<b>Federal Funds</b>
Shift Access for Infants & Mothers Program to GF and federal funds.	-\$78,440	\$27,454	\$50,986
Use S-CHIP federal funds for Prenatal Care to Undocumented Women in Medi-Cal.		-\$95,500	\$95,500
<b>Net Adjustments Overall by Year (GF and Proposition 99 Savings)</b>	<b>-78,440</b>	<b>-\$68,046</b>	<b>\$146,486</b>

**New Compromise Trailer Bill Language Proposed:** The Subcommittee is in receipt of language that has *tentative* agreement (as of Friday, May 6th) from all involved parties. (Final agreement should be known by Monday, May 9th.)

Using the trailer bill language adopted by the Subcommittee in its April 4th hearing, all parties have been meeting to craft a compromise. Based on the most recent discussions, this proposed compromise trailer bill language is as follows:

- (a) Through its courts, statutes, and under its Constitution, California protects a woman's right to reproductive privacy. California reaffirms these protections and specifically its Supreme Court decision in *People v. Belous* (1969) 71 Cal.2d 954, 966-68.
- (b) The State Department of Health Services and the Managed Risk Medical Insurance Board may accept or use monies under Title XXI of the federal Social Security Act (known as the State Children's Health Insurance Program, or S-CHIP), as interpreted in Title 42, Code of Federal Regulations, section 457.10, to fund services for women pursuant to Welfare and Institutions Code section 14007.7 (Medi-Cal) and Insurance Code sections 12695 et seq (Access for Infants and

Mothers (AIM)) only when, during the period of coverage, the woman is the beneficiary. The scope of services covered under Medi-Cal and AIM, as defined in statutes, regulations and state plans, is not altered by this section or the state plan amendment submitted pursuant to this section.

(c) California's S-CHIP plan and any amendments submitted and implemented pursuant to this section shall be consistent with subsections (a) and (b).

(d) This section is a declaration of existing law.

**Use of General Fund Savings and Proposition 99 Savings:** The Subcommittee captured \$68.046 million in General Fund savings, and \$78.440 million in Proposition 99 savings. But has not yet designated how these savings will be utilized for the budget year.

**The Governor's January budget proposes using these identified savings as follows** (See Hand Out chart that shows "Baseline versus Governor's Budget"):

- Uses \$13.5 million (Proposition 99 Funds) to backfill for General Fund support in the State Hospitals operated by the Department of Mental Health (for total expenditures of \$20.5 million in Proposition 99 Funds for the State Hospitals in 2005-06). Proposition 99 Funds were also used to backfill for some General Fund support in the State Hospitals last year. (No issues have been raised.)
- Increases by \$12.8 million (Proposition 99 Funds) for the Breast Cancer Early Detection Program due to caseload needs. (No issues have been raised.)
- Uses \$10 million (Proposition 99 Funds) to backfill for General Fund support in the Expanded Access to Primary Care (EAPC) Clinic Program. We have in previous years used Proposition 99 Funds for this purpose. (No issues have been raised.)
- Uses \$32.8 million (Proposition 99 Funds) to backfill for General Fund support in the Medi-Cal Program for full-scope services provided to legal immigrants. Proposition 99 Funds have never been used for this program before. (Subcommittee staff has concern.)
- Increases by \$1.1 million (Proposition 99 Funds) to correct for a technical error in the DHS state support item related to the Budget Act of 2003. (No issues have been raised.)

**Subcommittee Staff Comment and Recommendation:** First, it is recommended to adopt the revised trailer bill language that reflects the tentative compromise between interested parties.

Second, it is recommended to utilize the Proposition 99 Fund savings which are available for expenditure due to the federal S-CHIP Fund shifts for a purpose other than the Medi-Cal Legal Immigrants Program. The Medi-Cal Legal Immigrants Program is an important program that should not be destabilized using a declining revenue source such as Proposition 99 Funds. Further, the amount of funds that are being proposed by the Administration raises the issue of "supplanting" versus "supplementing".

Other "backfill" options are available that would better withstand the "supplementing" test. For example, these funds could be used to provide assistance in funding the Orthopedic Hospital Settlement agreement which occurred a few years ago regarding

providing increased reimbursement to hospitals for outpatient services. Yet another option would be to use some of the funds to support the Breast Cancer Treatment Program within the Medi-Cal Program that was implemented in 2000 (under this program the state draws down a 65 percent federal match).

Discussions with the Administration are occurring as to what options may be considered at the May Revision. Therefore, it is recommended to leave the exact funding allocations “open” until the May Revision pending an updating of overall Proposition 99 revenues, caseload adjustments, and considerations of other “backfill” options.

**Questions:**

1. Administration, Please provide comment regarding the revised language provided in the agenda, above.
2. DHS, Will the May Revision contain changes and adjustments to reflect revised Proposition 99 revenues, caseload and potentially other “backfill” options?

## **ISSUE “B”—Proposition 99 Funding and Obtaining a Federal Match**

**Issue:** Proposition 99 contains very explicit language regarding the use of the revenues obtained from the Proposition. The Proposition may be amended by a four-fifths vote of the Legislature as long as the amendment is consistent with the purposes of the Proposition.

There has been two occasions where changes have been made to the Proposition. The most recent one being AB 1763, Statutes of 2003, which was a trailer bill to the Budget Act of 2003. This statutory change enabled the Rural Demonstration Projects as operated by the Managed Risk Medical Insurance Board to draw down a federal match using the Proposition 99 funds as the state match.

**Subcommittee Staff Recommendation:** The three “indigent health care” accounts contained within Proposition 99—the Hospital Services Account, the Physicians Services Account and the Unallocated Account—could be used to draw down a federal match for various health care services.

Specifically, these funds could be more fully utilized to (1) draw down funds for the Medi-Cal Program (such as for the Breast Cancer Treatment Program—65 percent), (2) count towards a “certified public expenditure” (CPE), where applicable, and be used to draw federal funds under the pending Hospital Financing Waiver, and (3) draw down federal S-CHIP funds, where applicable. Overall it would provide increased flexibility for the state and counties, and would enable California to more fully utilize its limited state resources.

It is recommended *not* to include the Health Education Account or Research Account in this proposal because these two accounts receive funds from Proposition 10 as well and this would add a complicating factor. Further, the ability to match federal funds in these areas is more limited than in the “indigent health” accounts.

Therefore, it is recommended for the Subcommittee to adopt placeholder trailer bill legislation to change Proposition 99 to enable the Hospital Services Account, Physicians Account and Unallocated Account to be used to obtain a federal match, when applicable. This language will require a four-fifths vote of the Legislature to enact.

### **Questions:**

1. Administration, Do you have any comment from a technical assistance perspective regarding this recommendation?

**ISSUE “C”—Proposed Trailer Bill Language for Emergency Physician  
Funding (Proposition 99 Funding) (See Hand Out)**

**Issue:** For the past five years, the Legislature has been appropriating about \$25 million (Proposition 99 Funds) annually to reimburse emergency and on-call physicians for the costs of providing care to uninsured, indigent patients requiring emergency medical care.

The Governor’s budget proposes to continue this appropriation level. No issues have been raised regarding the proposed appropriation. In addition, the Administration has proposed trailer bill language which is needed in order for the DHS to appropriately allocate these funds.

However in recent discussions regarding the current-year allocation of these funds through SB 29 (Perata), Statutes of 2005, it became evident that modification to the budget-year allocation would be in order.

**Subcommittee Staff Comment and Recommendation:** The Subcommittee is in receipt of language (See Hand Out) which would clarify how the proposed budget amount of \$24.8 million (Proposition 99 Funds) would be allocated.

This language has been vetted with the Administration and Subcommittee staff. There is agreement that the proposed language would serve to ensure that reimbursements made using the \$24.8 million (Proposition 99 Funds) would be provided to physicians for losses incurred in providing emergency medical services directly to patients in emergency rooms. These physicians would need to submit claims or subsequently reconcile claims in order for the reimbursement to be made.

Therefore, it is recommended to adopt the proposed language as trailer bill legislation to ensure that the appropriation of \$24.8 million (Proposition 99 Funds) is utilized as intended.

**Questions:**

1. DHS, From a technical assistance basis, would the proposed language provide assistance in ensuring that the appropriation is expended as intended?

## **7. Domestic Violence Shelter Program—Unserved and Underserved (U/U)**

**Issue:** This issue was discussed in the March 14th Subcommittee hearing and was held “open” pending completion of a DHS survey regarding the targeting activities for special populations served by domestic violence shelters. This survey has now been completed and the results are discussed below.

With respect to the Governor’s budget, the Administration proposes an increase of \$1.1 million (\$515,000 General Fund, \$235,000 Domestic Violence Training Fund and \$350,000 in Nine West Settlement Funds) to restore funds used to assist shelters to serve communities of color, teens, disabled women and others that traditionally do not seek shelter services but are at high risk for domestic/intimate partner relationship violence.

Originally, an augmentation of \$2.5 million had been provided in the Budget Act of 1999 to focus services on “unserved” or “underserved” populations, with an emphasis on cultural and ethnic populations, so that groups experiencing domestic violence but not traditionally seeking assistance through the shelter program, would also be able to receive assistance. In the Budget Act of 2003, these funds were reduced by 50 percent, or \$1.1 million.

The DHS was able to temporarily redirect funds from the Domestic Violence Training and Education Fund to backfill for some funding in 2003-04 and 2004-05. However, this can no longer be fully done because these special funds have been depleted.

As noted in the March 14th hearing, the DHS was still in the process of discerning what would be the most effective use of these funds, pending completion of the survey and its results.

**Summary of the DHS Survey Results and Potential Use for Funds:** The DHS just released their analysis on May 5, 2005. Among other things, the DHS notes that there are three groups on which it would make sense to focus additional outreach efforts. These are as follows:

- Women with mental illness and substance abuse issues;
- Women with developmental disabilities; and
- Individuals who identify themselves as Lesbian, Gay, Bi-Sexual and Transgender.

Though the DHS would ideally like to release a statewide competitive Request for Proposal (RFP) for these three “priority” areas, it would take the DHS at least 9 months in order to proceed through the state’s process.

Therefore, in order to use the funds for 2005-06, the DHS is proposing to provide these funds to certain shelters to make shelter modifications for ADA compliance issues which have been identified by some shelters. Then for 2006-07, the funds could be used via an RFP as noted above.

**Additional Background—Domestic Violence Shelter Program Overall:** A total of \$22.9 million (\$22.3 million General Fund) is proposed for the DHS program. Of this amount, (1) \$21.3 million is allocated to 97 shelters for services, (2) \$262,00 is for data management and a women’s health survey, (3) \$85,000 is for technical assistance and training as required by statute, and (4) \$1.1 million is for unserved/underserved individuals. The existing program was established in statute in 1994 (AB 167, Freidman).

It should be noted that as a condition of receiving funds, shelters must, among other things, provide matching funds or in-kind contributions equivalent to not less than 20 percent of the grant they would receive.

**Subcommittee Staff Comment and Recommendation:** Clearly the intent of these funds is to provide assistance to underserved communities. Further, the DHS survey results have identified a very specific need for these limited resources. As such, it is recommended to utilize the \$1.1 million (total funds) for conducting outreach activities to the communities which have been identified in the survey and analysis, and not for the ADA compliance issues.

Further, it is recommended for the DHS to use an “Interagency” process in lieu of an RFP. Use of this mechanism is often done to use available expertise and to facilitate funding certain activities.

According the State Contracting Manual, there are limits on the ability of state agencies to contract with public colleges and universities. However, if the purpose of the Interagency agreement is to provide direct services to the public, as this would be, then an Interagency agreement (with a public college or university) could be done and if appropriate/needed, subcontracts could be done through the college or university for addressing some of the identified needs of these unique populations.

The following Budget Bill Language is proposed for this purpose (Item 4260-111-001):

Of the amount appropriated in this Item, up to \$1.1 million shall be used to fund interagency agreements to address non-traditional users of domestic shelter services as identified by the DHS in their recent survey. These funds shall be used specifically for those non-traditional users identified as being priorities by the DHS.

**Questions:**

1. DHS, Please describe the results of the recently completed survey.
2. DHS, Please briefly describe your revised proposal.
3. DHS, Please comment on the option of using an Interagency Agreement process (from a technical assistance perspective) as suggested above.

**D. Department of Mental Health—Capital Outlay Projects (Items 1 through 5)**

**1. Metropolitan State Hospital—Proposed Multiple Changes to the New Main Kitchen & Satellite Serving Kitchens**

**Issue:** The Subcommittee is in receipt of a DOF Capital Outlay Letter (received on May 2nd) which requests **all** of the following changes (*See Table below for a summary*):

- (1)** An increase of \$237,000 (General Fund) to reflect a revised cost estimate to the **construction phase** of the **6 satellite kitchen remodel** to account for the increased price of stainless steel;
- (2)** Reappropriation language for the General Fund amount appropriated in the Budget Act of 2004 for the **working drawing phase** of the **6 satellite kitchen remodel** project. This is needed because the Department of General Services estimate for this portion of the project was higher than anticipated.
- (3)** An increase of \$18 million (Lease Revenue Bonds) to fund increased costs resulting from additional seismic safety needs, unanticipated utility relocations, electrical rerouting, the increased costs of materials, and the inclusion of necessary equipment and food management software to the **main kitchen component**.
- (4)** Proposes to revert existing authority provided by the Budget Act of 2003 for preliminary plans, working drawings and construction for the main kitchen and satellite kitchens.

**Table—Summary of Metropolitan Kitchen Items**

<b>Budget Act of 2003 (Lease Revenue Bonds)</b>	<b>Budget Act of 2004</b>	<b>Requests Submitted for 20005-06 (Reflects Bond &amp; GF Changes)</b>
Appropriation of \$18.9 million for the entire project, including the main kitchen & 6 satellites: \$832,000 Preliminary Plans \$942,000 working drawings \$16.952 million construction	Project needs to be divided into two projects due to issues regarding the bond issuance. Bond funds will now be used for the main kitchen only. Reverts \$3.873 million (Bonds) for the project due to this change.	<b><u>Main kitchen (\$18 million--Bonds):</u></b> <b>1.</b> Revised working drawings= \$886,000. This proposal reflects a reversion of \$766,000 and an increase of \$120,000 (Bonds). <b>2.</b> Revised construction= \$17.144 million. This proposal reflects a reversion of \$13.255 million and an increase of \$3.9 million.
	Provided \$259,000 (General Fund) for working drawings.	<b><u>Satellite Kitchen</u></b> (\$5.3 million GF): <b>1.</b> Reappropriate \$259,000 (GF) for working drawings. <b>2.</b> Revised construction= \$5.282 million. This proposal reflects a reversion of \$5.045 million (Bonds) and an increase of \$5.282 million (GF). The January budget shifted the bond amount to GF support, and the Finance Letter reflects an increase of \$237,000 (GF).

The DMH states that these cost adjustments are necessary based on updates provided by the Department of General Services and as approved by the DOF..

The DOF is also proposing inclusion of the following “Supplemental Reporting Language” (two pieces as noted) which is traditionally adopted for capital outlay projects when changes have occurred. This proposed language is as follows:

*Supplemental Reporting Language-- Metropolitan State Hospital-Construct New Kitchen and Remodel Satellite Serving Kitchens: Satellite Serving Kitchen Component. General Fund: (Item 4440-301-0001).*

The amount of \$5,541,000 (CCCI 4339) is provided for working drawings (\$259,000), and construction (\$5,282,000) of six existing satellite kitchens and dining facilities. The satellite kitchen improvements include new kitchen equipment, seamless epoxy floors, ceramic tile walls, and acoustical ceiling tiles. The construction amount includes \$4,320,000 for the construction contract, \$302,000 for contingency, and \$660,000 for project administration. Working drawings will begin in July 2005 and the project bid in March 2006. Construction should be completed in January 2008.

*Supplemental Reporting Language-- Metropolitan State Hospital-Construct New Kitchen and Remodel Satellite Serving Kitchens: New Kitchen Component. Lease Revenue Bond Fund: (Item 4440-301-0660).*

The amount of \$18,030,000 (CCCI 4339) is provided for, working drawings (\$886,000), and construction (\$17,144,000) of a 26,100 square foot (square feet) central kitchen facility. The new main kitchen includes overhead fire sprinkler system, exterior plaster walls, standing seam metal roofing, new kitchen equipment, cook/chill system, high capacity food storage racks, large freezers, 48” high receiving dock with four overhead coiling doors, and a new 300 KVA emergency generator. The construction amount includes \$13,859,000 for the construction contract, \$693,000 for contingency, and \$2,592,000 for project administration. Working drawings will begin in July 2005 and the project bid in March 2006. Construction should be completed in January 2008.

**Background—Why the Remodel is Needed:** This is being proposed to meet requirements of DHS licensing and the “cook-chill” system. As discussed in our May 2nd hearing, renovation of the six Satellite Kitchens must now use General Fund support but the Main Kitchen remodel can be done with bond funds.

The Budget Act of 2003 appropriated \$18.7 million (Lease Revenue Bond Funds) to construct a new kitchen and remodel the six Satellite Kitchens at Metropolitan State Hospital. However, the DGS, DOF and DMH later recognized that selling bonds for the Satellite Kitchen component could not be done.

The six Satellite Kitchens must be remodeled to include new kitchen equipment, seamless epoxy floors, ceramic tile walls, and acoustical ceiling tiles (asbestos abatement and related environmental aspects are a concern). According to the DMH, the scope of the remodel remains the same as contained in the Budget Act of 2003 but the costs have increased.

**Prior Subcommittee Action:** In the Monday May 2nd hearing, the Subcommittee approved the Governor’s January budget to shift \$5 million from lease revenue bond funding to General Fund support to renovate all existing Satellite Kitchens and Dining Facilities at Metropolitan State Hospital.

**Subcommittee Staff Comment and Recommendation:** It is recommended to approve the Finance Letter changes and to adopt the Supplemental Reporting Language as shown in the agenda, as approved by the DOF and LAO. No issues have been raised by the LAO capital outlay specialists.

**Questions:**

1. DMH, Please provide a brief summary of the proposal.

**2. Metropolitan State Hospital—School Building (Construction Phase)**

**Issue:** The Subcommittee is in receipt of a DOF Capital Outlay Letter (received on May 2nd) which requests expenditure of \$8.754 million (Lease Revenue Bonds) to provide the State Hospital with a school building that meets Field Act requirements and provides for the educational needs of children residing at Metropolitan State Hospital. Metropolitan State Hospital is the only State Hospital that serves children and adolescents.

The DMH notes that the design of the school had to be modified to meet the State Fire Marshal requirements. The DMH states that this redesign, combined with the recent increase in material prices has caused the cost of the project to exceed an amount that can be approved within the State Public Works Board’s augmentation authority. As a result, a new lease revenue appropriation is requested for the construction phase of this project.

The DOF is also proposing inclusion of the following “Supplemental Reporting Language” which is traditionally adopted for capital outlay projects when changes have occurred. This proposed language is as follows:

*Supplemental Reporting Language-- Metropolitan State Hospital—Construct School Building.*

The amount of \$8,754,000 is provided for construction of a 27,000 square feet school with administrative offices adjacent to the living units of the Youth Treatment Program. The amount for construction includes \$375,000 for contingencies, \$871,000 for project management, and \$7,508,000 for construction contracts. Approval to go to bid is scheduled for July 2005. Construction will begin in January 2006 with the project expected to be completed in May 2007.

**Subcommittee Staff Comment and Recommendation:** It is recommended to approve the Finance Letter changes and to adopt the Supplemental Reporting Language as shown in the agenda, as approved by the DOF and LAO. No issues have been raised by the LAO capital outlay specialists.

**Questions:**

1. DMH, Please provide a brief summary of the proposal.

### **3. Patton State Hospital—Renovate Admissions Suite**

**Issue:** The Subcommittee is in receipt of a DOF Capital Outlay Letter (received on May 2nd) which requests expenditure of \$30.146 million (Lease Revenue Bonds) in a new lease revenue appropriation.

The DMH states that when lease revenue bonds for the first phase of this project were sold, the state was required to perform an immediate seismic retrofit of the building. As a result, funding was provided for the retrofit prior to completing a needs analysis, thereby leading to a project that was under-funded in the original appropriation.

The DOF states that with completion of preliminary plans, it has been determined that the seismic retrofit would require the replacement of all interior walls and ceilings, as well as the installation of sprinklers. As such, the Administration is requesting a new lease revenue appropriation for the working drawings and construction phases of the project.

The DOF is also proposing inclusion of the following “Supplemental Reporting Language” which is traditionally adopted for capital outlay projects when changes have occurred. This proposed language is as follows:

*Supplemental Reporting Language--Patton State Hospital—Renovate Admission Suite and FLSEI Phases II & III—EB Building. Lease Revenue Bond (Item 4440-301-0660).*

The amount of \$ 30,146,000 (CCCI 4339) is provided for working drawings (\$1,164,000), and construction (\$28,982,000) to renovate the Admission Suite, complete the FLSEI renovations of the EB Building, and to seismically retrofit the building. The construction amount includes \$22,548,000 for the construction contract, \$2,103,000 for contingency, \$3,629,000 for project administration, and \$702,000 for agency-retained items. Working Drawings should begin July 2005 and the project bid in June 2006. Construction should be completed in November 2009.

**Subcommittee Staff Comment and Recommendation:** It is recommended to approve the Finance Letter changes and to adopt the Supplemental Reporting Language as shown in the agenda, as approved by the DOF and LAO. No issues have been raised by the LAO capital outlay specialists.

#### **Questions:**

1. DMH, Please provide a brief summary of the proposal.

#### **4. Budget Bill Language for the DMH Capital Outlay Projects**

**Issue:** The Subcommittee is in receipt of a DOF Capital Outlay Letter that requests approval of five pieces of Budget Bill Language for Item 440-301-0660 (DMH-Capital Outlay-Lease Revenue Bond Funds). The proposed language is as follows:

**Provisions:**

1. The State Public Works Board may issue lease revenue bonds, notes or bond anticipation notes pursuant to Chapter 5 (commencing with Section 15830) of Part 10b of Division 3 of Title 2 of the Government Code to finance all phases of the project authorized by this item.
2. The State Public Works Board and the Department of Mental Health may obtain interim financing of the project costs authorized in this item from any appropriate source, including, but not limited to, Section 15849.1 of the Government Code and the Pooled Money Investment Account pursuant to Sections 16312 and 16313 of the Government Code.
3. The State Public Works Board may authorize the augmentation of the cost of each phase of the projects scheduled in this item pursuant to the Board's authority under Section 13332.11 of the Government Code. In addition, the State Public Works Board may authorize any additional amount necessary to establish a reasonable construction reserve and to pay the cost of financing, including the payment of interest during construction of the project, the costs of financing a debt service fund, and the cost of issuance of permanent financing for the project. This additional amount may include interest payable on any interim financing obtained.
4. This Department is authorized and directed to execute and deliver any and all leases, contracts, agreements, or other documents necessary or advisable to consummate the sale of bonds or otherwise effectuate the financing of the scheduled projects.
5. The State Public Works Board shall not be deemed to be the lead or responsible agency for purposes of the CA Environmental Quality Act (Division 13, commencing with Section 21000, of the Public Resources Code) for any activities under the State Building Construction Act of 1955 (Part 10b, commencing with Section 15800, of the Division 3 of Title 2 of the Government Code). This section does not exempt this department from the requirements of the CA Environmental Quality Act. This section is intended to be declarative of existing law.

The DOF states that the above five provisions of language are standard language necessary for any project financed with Lease Revenue Bonds, regardless of the department. The language provides authority to sell bonds and perform interim financing for project costs. It also authorizes the State Public Works Board to augment projects necessary pursuant to existing law (Section 13332.11 of Government Code). It also

clarifies the role of the DMH when a project is funded through lease revenue bonds. Finally it reaffirms the requirements of the CA Environmental Quality Act regarding these projects.

**Subcommittee Staff Comment and Recommendation:** It is recommended to approve the five pieces of Budget Bill Language as proposed by the DOF for the DMH identified projects. No issues have been raised by the LAO capital outlay specialists.

**Questions:**

1. Administration, Please provide a brief summary of the proposal.